



Workshop Information Cover Sheet

Instructions to the Group Leaders: Please provide the requested details about this Workshop. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to the New Jersey Department of Human Services.

1. Site Name: _____
Address: _____
City: _____ State: _____ Zip: _____
County: _____

2. Name of organization licensed to offer program: _____

3. Workshop Leaders' Names (please provide full first and last names): If we may contact you with questions about these forms, please provide your daytime phone number as well.

First Name	Last Name		Phone
_____	_____	<input type="checkbox"/> Staff or <input type="checkbox"/> Volunteer	_____
_____	_____	<input type="checkbox"/> Staff or <input type="checkbox"/> Volunteer	_____

4. Workshop Start Date (mm/dd/yyyy): _____ / _____ / _____
End Date (mm/dd/yyyy): _____ / _____ / _____

5. Did you offer a "Session 0" with this workshop? (Session 0 is an optional pre-workshop session. Not all workshops offer a Session 0.)

- ☐ Yes
☐ No
☐ Don't Know

6. What type of workshop is this? (Mark only one.)

- ☐ Chronic Disease Self-Management Program (CDSMP)
☐ Tomando Control de su Salud (Spanish CDSMP)
☐ Diabetes Self-Management Program (DSMP)
☐ Manejo Personal de la Diabetes (Spanish DSMP)

7. Please check which language you used when leading this workshop:

☐ English ☐ Spanish ☐ Chinese ☐ French ☐ Hindi ☐ Vietnamese ☐ Other: _____

For Survey Coordinator Use Only

Host Organization Name: _____

Funding Source for this Workshop: ☐ DoAS ☐ OMMH ☐ FHS ☐ Title IID

☐ CDC ☐ Other Fed. ☐ Foundation ☐ Fee/Self-Pay ☐ Other: _____

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8. Number of participants **enrolled** attending at least 1 session (excluding "Session 0"): _____
9. Number of participants who **completed at least 4 sessions** (excluding "Session 0"): _____
10. Number of *Participant Information Surveys* included in the returned packet: _____

If the number of forms is fewer than the number of participants noted in #9 above, please provide a brief explanation (e.g., illness, refusal, loss or destruction of forms, etc.):

10. If you charge the participants a fee to attend this workshop, please indicate the amount: _____

Forms Checklist Examples

Please return the following forms to the Survey Coordinator (contact information below) within one (1) week after the final session:

- ☐ This *Workshop Information Cover Sheet*
- ☐ *Attendance Log*
- ☐ All completed *Participant Information Surveys*

Send completed forms to:

Andrea Brandsness
New Jersey Department of Human Services
Division of Aging Services
P.O. Box 807
Trenton, NJ 08625-0807

Questions can be directed to:

Andrea Brandsness
andrea.brandsness@dhs.state.nj.us or 609-588-2517

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0985-0036. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Administration for Community Living, 1 Massachusetts Avenue, N.W., Room 5203, Washington, D.C. 20001, Attention: PRA Reports Clearance Officer